

Child and Adult Care Food Program (CACFP)

INCOME ELIGIBILITY APPLICATION FOR FAMILY DAY CARE HOME PROVIDERS' OWN CHILDREN

For instructions on completing this form, see [Instructions for Income Eligibility Application for Family Day Care Home Providers' Own Children](#).

PART 1 — CHILD INFORMATION

Provider's Name: _____

Child's Name: _____ Age: _____ Birth Date (month, day, year): _____

Child's Normal Child Care Schedule (Check all days that apply):

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Child's Normal Hours of Care (Include time and circle AM or PM):

_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM

Normal Meal Services Provided to Child (Check all meals/snacks that apply):

☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

PART 2A — PARTICIPANTS CATEGORICALLY ELIGIBLE AS TIER I FOR CACFP BENEFITS

Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, and households with foster children: *Complete this part and part 3. Do **not** complete part 2B.*

SNAP Case Number: _____ TFA Case Number: _____ Check if foster child: ☐

PART 2B — ALL OTHER HOUSEHOLDS

If you did not complete part 2A, complete this part and part 3.

Names of all household members <i>List everyone in the household, including the child listed in part 1 above</i>	Gross income and how often it was received: Indicate if income was received monthly, two times a month, every two weeks or weekly by placing the amount of income in the appropriate frequency box. <i>You must place the income in the appropriate frequency box.</i>											
	Earnings from Work (before deductions) – Job 1				Public Assistance/ Alimony/Child Support				Pensions/Retirement/Social Security/All Other Income			
Names	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly
(Example) Jane Smith	\$200					\$134						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												

PART 3 — CONTACT INFORMATION, SIGNATURE AND SOCIAL SECURITY NUMBER

*The provider must **sign and date** this form before it can be approved.*

I certify (promise) that all information on this form is true and that all income is reported. I understand that the day care home will receive federal funds based on the information I provide. I understand that CACFP officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Printed Name of Provider: _____ Signature: _____

Date: _____ Last four digits of Social Security Number (SSN): XXX-XX-_____ ☐ I do not have a SSN

Home Telephone: _____ Work Telephone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

INCOME ELIGIBILITY APPLICATION FOR HOUSEHOLDS FOR PROVIDERS' OWN CHILDREN

PART 4 — RACIAL AND ETHNIC IDENTITY (OPTIONAL) *You are not required to complete this part.*

Ethnicity (Check one):

- ☐ Hispanic/ Latino
☐ Not Hispanic/Latino

Race (Check one or more):

- ☐ Asian
☐ White
☐ Black or African American

- ☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

FOR SPONSOR USE ONLY – DO NOT WRITE BELOW THIS LINE

Annual Income Conversion: Weekly X 52 • Every 2 weeks X 26 • Twice a Month X 24 • Monthly X 12

Total family income: \$ _____ Family size: _____ OR ☐ SNAP/TFA household ☐ Foster Child

☐ Eligible as Tier I ☐ Not eligible as Tier I

Sponsor Eligibility Official: _____ Date: _____
Signature



For information on the CACFP, visit the CSDE's [CACFP Web site](#) or contact the [CACFP staff](#) in the Connecticut State Department of Education, Bureau of Health/Nutrition, Family Services and Adult Education, 25 Industrial Park Road, Middletown, CT 06457.

This form is available at www.sde.ct.gov/sde/lib/sde/pdf/deps/nutrition/cacfp/forms/IEAppProvOwn.pdf.